NextGen Patient Record

Name: RICHARDSON, JONATHAN C
DOB: [redacted]

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Disability Classification

Flu Screening Form

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Nurse Visit

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chm_class_orders
Nurse Visit

Encounter: 7/30/2018 9:08:00 AM

med_bh_indiv_prog_note

Encounter: 7/21/2018 8:02:19 AM

Disability Classification
Heat Stress Quesionnaire
med_chm_annual_nurse_enc
Medical Status Classification
Mental Status Classification

Encounter: 7/12/2018 1:45:00 PM

chm_administrative_note

Encounter: 7/12/2018 8:22:02 AM

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chm_xray_requisition

Nurse Visit

Encounter: 1/5/2018 10:13:24 AM

chm_nonformulary_drug_request

med_chm_provider_visit

Encounter: 1/3/2018 3:18:58 PM

med_bh_indiv_prog_note

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	12/27/2019 10:25 AM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 10:15 AM

End time: 00 hours, 40 minutes

Duration: 00 hours, 40 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. seen for scheduled follow-up regarding ongoing gender dysphoria evaluation. Ofd. identifies as a transgender woman and will be referred to by feminine pronouns per her request. She presents initially irritable due to the appointment starting late. She assumed it was because the medical officer did not notify the psychologist of her presence, but was somewhat placated when the psychologist explained that a meeting had run late. (continued below)

New issues/stressors/extraordinary events presented today: None reported

Explanation: Ofd. expressed that she has previous negative history with the medical officer and made an assumption that in retrospect was inaccurate. Ofd. also thanked the psychologist for addressing this obstacle to therapeutic rapport and said that she appreciates this attention to the process of therapy. She asked about whether testing had been received, and was pleased to learn that it has. She asked to use the remainder of the appointment to complete the MMPI-2.

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Determine whether the offender meets criteria for gender dysphoria / determine appropriate treatment	Gather history and report of past and present symptoms that may support a diagnosis of gender dysphoria

Interventions/Methods Provided:
Psychologist addressed offender's irritability and utilized a process-oriented approach to therapy to overcome the emotional obstacles that appeared to be present. Psychologist reviewed the instructions for the MMPI with the offender and set her up at a table in the psychologist's office to begin the examination, with the instruction that the venue may have to be changed if the offender has not completed the test by the time the therapy session has ended. Agreed to meet again when the test results are returned.
Response to Interventions/Progress Toward Goals and Objectives:
Ofd. was initially irritated but quickly overcame this when it was directly addressed and processed. Ofd. very excited to have the testing to complete as a step in the process of evaluating her for gender dysphoria.

Current Assessment

Individual's progress: Good progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with medications. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments

Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		12/27/2019	12/27/2019	No				
Property	Denies		12/27/2019	12/27/2019	No				
Homicide	Denies		12/27/2019	12/27/2019	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN

No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V

Current GAF: 68
Date: 12/27/2019.

Highest GAF: 68
Date: 08/16/2019.

Plan and Additional Information

Date	Order Description
01/10/2020	MHP follow-up for Ind Tx / Gender Dysphoria Eval

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 12/27/2019

Behavioral Health Billing

Start time:	10:15 AM
End time:	10:55 AM
Duration:	00 hours, 40 minutes
Modifier:	N/A

Document generated by: Richard J. Gale, PsyD 12/27/2019 10:37 AM

Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	12/04/2019 12:11 PM
VISIT TYPE:	Nurse Visit

Nurse Visit

Reason for visit: dressing change

Nurse Protocols:

Review/Comments

Patient smokes 20.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization	inhale 3 milliliter by nebulization route 2 times every day, as needed	N		
ipratropium bromide 0.02 % solution for inhalation	inhale 2.5 milliliter by inhalation route twice daily as needed, MIX WITH ALBUTEROL	N		
Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N		

General Comments

pt came to HCU around 0740 for dressing change to neck. Placed bandaid on neck, still healing. Pt left HCU in stable condition and went back to housing unit.

Document generated by: John Velarde, RN 12/04/2019 12:13 PM

Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	12/03/2019 7:32 AM
VISIT TYPE:	Nurse Visit

Nurse Visit

Reason for visit: Dressing change

Nurse Protocols:
Review/Comments
Patient smokes 20.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization	inhale 3 milliliter by nebulization route 2 times every day, as needed	N		
ipratropium bromide 0.02 % solution for inhalation	inhale 2.5 milliliter by inhalation route twice daily as needed, MIX WITH ALBUTEROL	N		
Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N		

General Comments

Offender presents for wound care. Area to left side of neck is dry et scabbed over. Small amount antibiotic oint applied and covered with large bandaid. Extra large bandaid given to offender for back up.

Document generated by: Shannon S. McCord, LPN 12/03/2019 07:34 AM

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	12/02/2019 10:07 AM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 10:07 AM

End time: 00 hours, 45 minutes

Duration: 00 hours, 45 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. arrived as scheduled for follow-up therapy visit. Ofd. who identifies as trans woman, said she hoped it would be to complete the psychological testing discussed previously to aid in the diagnosis and treatment planning of reported gender dysphoria. Otherwise, ofd. reports no serious new concerns. She has continued to have ups and downs socially, and discussed beginning to identify another offender as a "spiritual friend." This is a significant step for her regarding interpersonal intimacy.

New issues/stressors/extraordinary events presented today: None reported

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Alleviate depressive symptoms	Identifies negative thinking supporting depression

Interventions/Methods Provided:
Psychologist followed up with regional staff regarding the availability of MMPI testing materials. Processed the meaning of "spiritual friend" with ofd. and the significance of being willing to refer to another offender as a friend in any capacity. Reinforced the importance of interpersonal connectedness and support.
Response to Interventions/Progress Toward Goals and Objectives:
Stable.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is improved. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is improved. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		12/02/2019	12/02/2019	No				
Property	Denies		12/02/2019	12/02/2019	No				
Homicide	Denies		12/02/2019	12/02/2019	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 68
Date: 12/02/2019.

Highest GAF: 68
Date: 08/16/2019.

Plan and Additional Information

Date	Order Description
12/16/2019	MHP follow-up for Ind Tx

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 12/16/2019

Behavioral Health Billing

Start time: 10:07 AM
End time: 10:52 AM
Duration: 00 hours, 45 minutes
Modifier: N/A

Document generated by: Richard J. Gale, PsyD 12/16/2019 11:56 AM

Indiana Government Center South

302 W. Washington Street
Indianapolis, IN 46204

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	12/02/2019 7:35 AM
VISIT TYPE:	Nurse Visit

Nurse Visit

Reason for visit: Drsg change

Nurse Protocols:

Review/Comments

Patient smokes 20.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization	inhale 3 milliliter by nebulization route 2 times every day, as needed	N		
ipratropium bromide 0.02 % solution for inhalation	inhale 2.5 milliliter by inhalation route twice daily as needed, MIX WITH ALBUTEROL	N		
Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N		

General Comments

Offender presents to medical for dressing change. Offender states that he washed his wound this morning. Antibiotic ointment applied to left side of neck and wound covered with a large bandaid. Offender was sent to kitchen with one large bandaid as well.

Document generated by: Alisha M. Richey, LPN 12/02/2019 07:36 AM

Indianapolis, IN 46204

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	12/01/2019 12:09 PM
VISIT TYPE:	Nurse Visit

Nurse Visit

Reason for visit: Dressing change

Statement of complaint (in patient's words): Dressing change Left neck

Nurse Protocols:

Review/Comments

Patient smokes 20.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization	inhale 3 milliliter by nebulization route 2 times every day, as needed	N		
ipratropium bromide 0.02 % solution for inhalation	inhale 2.5 milliliter by inhalation route twice daily as needed, MIX WITH ALBUTEROL	N		
Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N		

General Comments

Offender to medical for dressing change left neck. Offender cleansed wound before arriving to medical. Applied bacitracin and large bandaid.

Document generated by: Ryan N. Wadsworth, RN 12/01/2019 12:10 PM

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	11/30/2019 7:21 AM
VISIT TYPE:	Nurse Visit

Nurse Visit

Reason for visit: Sick Call

Statement of complaint (in patient's words): sick call for dressing change

Nurse Protocols:

ALTERATION IN SKIN INTEGRITY

Subjective:
Affected body part? Left neck
How did it occur? spontaneously
When did it occur? 2 Days
Recent allergen exposure? no
Patient complains of: pain,

Objective:
Wound Location: left neck.
Wound Size: L: 2.50 cm. W: 1.50 cm. D: 0.00 cm.

Examination shows pustules, vesicles, or furuncles; erythemic area with short well defined slightly raised border

Signs & symptoms of infection: increased redness,

Date of last tetanus booster: 06/09/2019

Assessment:
Alteration in skin integrity.
Potential or actual infection.

Review/Comments
Patient smokes 20.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization	inhale 3 milliliter by nebulization route 2 times every day, as needed	N		
ipratropium bromide 0.02 % solution for inhalation	inhale 2.5 milliliter by inhalation route twice daily as needed, MIX WITH ALBUTEROL	N		
Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N		

Orders

Status	Order	Timeframe	Frequency	Duration	Stop Date
completed	Medication allergies and other contraindications reviewed & pregnancy ruled out prior to treatment				
completed	Dressing applied/issued # 1.				
completed	Sick call if symptoms do not subside or become more severe				
completed	Patient education provided				

General Comments

Offender presented to nurse sick call for dressing change to area on left side of neck. Area remains unchanged in size, 1 1/2cm x 2 1/2cm with well defined raised red border. Now with small white pustules in the interior x 6. No weeping noted today. Area able to be confined by large band-aid dressing. Will continue to complete dressing changes and monitor progression. If worsens or does not improve, will refer to MD for evaluation.

Education	Date Provided	Provided By
Dressing applied/issued # 1.	11/30/2019	Kelly K. Smith, RN
Medication allergies and other contraindications reviewed & pregnancy ruled out prior to treatment	11/30/2019	Kelly K. Smith, RN
Patient education provided	11/30/2019	Kelly K. Smith, RN

Document generated by: Kelly K. Smith, RN 11/30/2019 07:27 AM

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	11/29/2019 7:22 AM
VISIT TYPE:	Nurse Visit

Nurse Visit

Reason for visit: Dressing Change

Nurse Protocols:
Review/Comments
Patient smokes 20.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization	inhale 3 milliliter by nebulization route 2 times every day, as needed	N		
ipratropium bromide 0.02 % solution for inhalation	inhale 2.5 milliliter by inhalation route twice daily as needed, MIX WITH ALBUTEROL	N		
Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N		

General Comments

Offender seen in medical this AM r/t dressing change. Offender has no discharge at this time. Area covered with large bandaide.

Document generated by: Lara E. Conway, RN 11/29/2019 07:24 AM

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	11/08/2019 4:54 PM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 1:00 PM

End time: 00 hours, 55 minutes

Duration: 00 hours, 55 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. seen for scheduled follow-up therapy visit and ongoing evaluation of gender dysphoria diagnosis. Discussed thoughts of how her crime may have been influenced by/related to gender dysphoria even before the offender had fully formed her understanding that she identified as a woman. Linked this to envy over the victim having a female body, which the offender wanted to have. Discussed mentally separating friends from the crimes they have committed. Denies SI/HI.

New issues/stressors/extraordinary events presented today: None reported

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Alleviate depressive symptoms	Verbalizes increased feelings of self worth
Determine whether the offender meets criteria for gender dysphoria / determine appropriate treatment	Gather history and report of past and present symptoms that may support a diagnosis of gender dysphoria

Interventions/Methods Provided:
Psychologist facilited converation with offender regarding the impact of transgender identity and inability to feel supported in expressing it. Educated the offender about the policy and process of diagnosis and treatment for gender dysphoria in IDOC and asked for continued patience while the process runs its course, which the offender agreed to. Explored issues of acceptance and rejection by others since the offender has become more open with others recently regarding transgender identity.
Response to Interventions/Progress Toward Goals and Objectives:
Stable, doing well, becoming more open in talking with psychologist about sexual identity and orientation issues.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.

Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		11/08/2019	11/08/2019	No				
Property	Denies		11/08/2019	11/08/2019	No				
Homicide	Denies		11/08/2019	11/08/2019	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 68
Date: 11/08/2019.

Highest GAF: 68
Date: 08/16/2019.

Plan and Additional Information

Date	Order Description
11/29/2019	MHP follow-up for Ind Tx

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 11/08/2019

Behavioral Health Billing

Start time: 1:00 PM
End time: 1:55 PM
Duration: 00 hours, 55 minutes
Modifier: N/A

Document generated by: Richard J. Gale, PsyD 11/08/2019 04:59 PM

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	10/21/2019 3:29 PM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 2:00 PM

End time: 00 hours, 55 minutes

Duration: 00 hours, 55 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. seen for individual therapy and to discuss the results of today's conference call regarding gender dysphoria and other psychological diagnoses. Ofd, who identifies as a woman, was receptive and shared that she does not necesarily expect things to move quickly. What she is committed to is trying to get treatment started before exitting prison in order to create the best chance possible of a successful readjustment to society.

New issues/stressors/extraordinary events presented today: None reported

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Determine whether the offender meets criteria for gender dysphoria / determine appropriate treatment	Gather history and report of past and present symptoms that may support a diagnosis of gender dysphoria

Interventions/Methods Provided:
Psychologist summarized the gender dysphoria conference call held earlier for the offender and discussed/answered questions. Explored the relationship between trangender identity and problems the offender has experienced throughout her life, including commission of the crime for which she is incarcerated. Discussed history of diagnosis and the offender's belief that it was her manipulation of psychologists for the purpose of getting medication referrals that led to most of those diagnoses.
Response to Interventions/Progress Toward Goals and Objectives:
Stable. Accepting of information shared.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant and improved. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with medications. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.

Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		10/21/2019	10/21/2019	No				
Property	Denies		10/21/2019	10/21/2019	No				
Homicide	Denies		10/21/2019	10/21/2019	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS I & II

#	Axis	Description	Impression/Differential Dx
1	Axis I	Major depressive disorder, recurrent episode, mild degree (296.31)	

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 68
Date: 10/21/2019.

Highest GAF: 68
Date: 08/16/2019.

Plan and Additional Information

Date	Order Description
11/11/2019	MHP follow-up for Ind Tx

Plan/Additional Information:
Will change the diagnosis of MDD, recurrent, severe with psychotic features to more accurately reflect the appropriate diagnosis of recurrent major depression with currently mild presentation.

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 10/21/2019

Behavioral Health Billing

Start time:	2:00 PM
End time:	2:55 PM
Duration:	00 hours, 55 minutes
Modifier:	N/A

Document generated by: Richard J. Gale, PsyD 10/21/2019 03:59 PM

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	10/21/2019 11:44 AM
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 11:00 AM

End time: 00 hours, 45 minutes

Duration: 00 hours, 45 minutes

Individuals Present/Support Resources

Contact type:
Phone conversation
Individual not present.

Contact type:
Others Present: Deanna Dwenger, Psy.D.; Ellen Keris, Ph.D.

Goals, Objectives, and Interventions Addressed Today

Interventions/Methods Provided:
Conference call with Drs. Dwenger, Keris, and Gale to discuss offender's gender dysphoria assessment, review appropriateness of diagnosis, and discuss further direction of assessment and treatment planning.

Dr. Gale presented case summary and discussed diagnostic considerations in light of other symptoms and ofd's psychiatric history. Explored the difficulty in separating symptoms of borderline personality disorder from symptoms of gender dysphoria. Discussed the legacy diagnosis of severe depression with psychotic features and agreed to change that in light of its lack of recent accuracy (no recent hallucinations, psychotic thinking, or other symptoms of psychosis. Depression has only been mild to moderate).

The consensus of the call was that additional time is needed for further assessment of symptoms and clarification of what symptoms are likely associated with personality disorder versus possible gender dysphoria. Discussed completion of MMPI and possibly other assessment instruments to help clarify the diagnostic picture.

Plan is to discuss the outcome of the call with the offender during an appointment planned for later this afternoon and defer referral for medical treatment, including hormone therapy, until a firmer diagnostic picture is created. Will schedule a follow-up conference call to review additional information when such a phone call is appropriate, likely in several months.

Will attach scans of the psychologist's gender dysphoria assessment notes compiled during several previous appointments with Richardson. The information in these documents forms the basis of the conference call that is described in this note.

Risk Assessment

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 68
Date: 09/26/2019.

Highest GAF: 68
Date: 08/16/2019.

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 10/21/2019

Behavioral Health Billing

Start time:	11:00 AM
End time:	11:45 AM
Duration:	00 hours, 45 minutes
Modifier:	N/A

Document generated by: Richard J. Gale, PsyD 10/21/2019 11:53 AM

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DEPARTMENT OF CORRECTIONS
ADMINISTRATIVE NOTE

SITE: CIC
COMPLETED BY: Andrea K. Fulton, MA 10/15/2019 7:38 AM

State of Indiana
Department of Correction

Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	10/15/2019 7:38 AM
VISIT TYPE:	Chart Update

Tracking Information

Date of occurrence 10/15/2019

Issue

Signed refusal for CC labs.

Additional comments

ADvised to have periodic labs draws to help monitor his medical conditions.

Provider: Yoko Savino MD
Document generated by: Andrea K. Fulton, MA 10/15/2019 07:39 AM

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STATE000538
Exhibit 69

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DATE: 10/14/2019 10:20 AM
VISIT TYPE: Chronic Care Visit

History of Present Illness:

1. asthma
   The initial visit date was 02/12/2008. Symptoms of asthma began in 1984. Pertinent negatives include awakening with cough, awakening with dyspnea, awakening with wheeze, dry cough, dyspnea at rest, dyspnea with intense exercise, dyspnea with moderate exercise, excessive sputum, hemoptysis, hoarseness, irregular heartbeat/palpitations, mucus plug production, oral thrush, pleuritic pain, post nasal drainage, productive cough, reflux, seasonal rhinitis symptoms, sinusitis, stridor, tremor after inhaler use and wheezing.

PROBLEM LIST:

Problem Description	Onset Date	Chronic	Clinical Status	Notes
Severe recurrent major depression with psychotic features	01/17/2011	N		
Gastroesophageal reflux disease	02/19/2015	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Esophageal reflux, 530.81, added by Paul A. Talbot, MD, with responsible provider Paul A. Talbot MD. Onset date 02/19/2015.
Borderline personality disorder	05/04/2010	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Borderline personality disorder, 301.83, added by Darla Hinshaw, MD, with responsible provider . Onset date 05/04/2010; Axis II.

Problem List (not yet mapped to SNOMED-CT®):

Problem Description	Onset Date	Notes
Asthma	03/19/2007	

Polysubstance Dependence	01/17/2011
major depression in remission	01/17/2011
Nonspecific reaction to tuberculin skin test witho	02/01/2011
Epilepsy	06/11/2015

Allergies

Ingredient	Reaction	Medication Name	Comment
PENICILLINS	Rash		
IBUPROFEN	Rash		
CEFTRIAXONE SODIUM	SOB, chest pressure, rash	ROCEPHIN	Pt was given 0.5mg Epi x1 and NS IV w/ good results

Review of Systems

System	Neg/Pos	Details
ENMT	Negative	Hoarseness, oral thrush, post-nasal drainage and sinusitis.
Respiratory	Negative	Awakening with cough, awakening with dyspnea, awakening with wheezing, dry cough, dyspnea at rest, dyspnea with intense exercise, dyspnea with moderate exercise, excessive sputum, hemoptysis, mucus plug production, pleuritic pain, productive cough, stridor and wheezing.
Cardio	Negative	Irregular heartbeat/palpitations.
GI	Negative	Reflux.
Endocrine	Negative	Tremors.
Allergic/Immuno	Negative	Seasonal rhinitis symptoms.

Vital Signs

Height

Time	ft	in	cm	Last Measured	Height Position
10:21 AM	5.0	11.0	0.0	02/08/2014	0

Weight/BSA/BMI

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
10:21 AM	200.0		90.718	dressed with shoes	27.89	

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
10:21 AM	130/90	sitting	right	arm	manual	adult

Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
10:21 AM	98.30	36.8	oral	71	regular	16

Pulse Oximetry/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
10:21 AM	98		RA			21			

Peak Flow

RICHARDSON, JONATHAN 127630 [redacted] 10/14/2019 10:20 AM 50/531